Arizona Medical Board

9545 East Doubletree Ranch Road • Scottsdale, Arizona 85258
Home Page: http://www.azmd.gov
Telephone (480) 551-2700 • Fax (480) 551-2704 • In-State Toll Free (877) 255-2212

FINAL MINUTES FOR REGULAR SESSION MEETING
Held at 9:30 a.m. on June 7, 2006, and 8:00 a.m. on June 8, 2006, 9535 E. Doubletree Ranch Road · Scottsdale, Arizona

Board Members

Robert P. Goldfarb, M.D., F.A.C.S., Chair
William R. Martin III, M.D., Vice Chair
Douglas D. Lee, M.D., Secretary
Patrick N. Connell, M.D.
Patricia Griffen
Tim. B. Hunter, M.D.
Becky Jordan
Ram R. Krishna, M.D.
Lorraine L. Mackstaller, M.D.
Sharon B. Megdal, Ph.D.
Dona Pardo, Ph.D., R.N.
Paul M. Petelin Sr., M.D.

WEDNESDAY, June 7, 2006

Executive Director's Report

Investigations Office Report – Regulations Division

The performance indicators will be expanded to include other areas of the agency at the next Arizona Medical Board meeting. At this meeting, however, Mr. Miller summarized the performance indicators from the Investigations Office. The case load has been decreased by 65% since this same time last year. It previously took the agency approximately four months to complete an investigation and it now takes less than 180 days to complete one. This is in compliance with the Auditor General's request.

The definition of "completed cases" is cases in which the investigation is complete, but the case could be waiting to come to a Board Meeting or is at Formal Hearing.

Tim B. Hunter, M.D. recognized Bernadette Phelan, Ph.D. for her time of service with the Arizona Medical Board as Assistant Director and congratulated her on her new career opportunity.

Status of IT Request For Proposal – Quality Control Division

The agency will most likely have a vendor by the end of the month for the new database.

Physician Health Program (PHP) Office Report

The PHP program is in the process of developing guidelines and has come across some issues that will need the Board's guidance at a later date.

Legislation Report

There were two bills recently signed by the Governor that created new areas of unprofessional conduct. The first bill makes it an act of unprofessional conduct for a health care provider to bill the patient directly for laboratory services. Mr. Miller said the laboratory is required to bill patients for services to prevent double billing by the physicians. The second bill makes it an act of unprofessional conduct for a physician to abandon his/her patient's medical records. The bill gives regulatory boards the authority to take possession of the records, but the bill does not require a board to take possession of any abandoned records.

The Board's Omnibus bill also passed and was signed by the Governor. This bill allows the Board to now issue non-disciplinary orders for Continuing Medical Education (CME). Previously when the Board issued CME it had to place a physician on Probation.

Legal Advisor Report

Consistency in Board Actions

Christine Cassetta, Board Legal Counsel asked the Board for guidance for Staff in case involving wrong site or wrong "item" surgery. Robert P. Goldfarb, M.D., F.A.C.S., said the Board is seeing many wrong site surgery cases and he believes the community expects a surgeon to verify he/she has the correct patient, will be performing the correct procedure, has the correct x-rays and MRI scans and that the films are placed correctly on view box and not reversed or backwards so that the correct side is reflected. The surgeon must also confirm he/she has the correct pathology report or x-ray report and that there are no discrepancies in the report. Dr. Goldfarb noted at times a radiologist may dictate the word "right" when "left" is meant and vice versa. Dr. Goldfarb said if a surgeon delegates any of above duties to someone else, it is the surgeon's responsibility that the tasks have been completed correctly.

Dr. Goldfarb said it is the surgeon's responsibility to correctly set any equipment required for surgery, such as laser machines for lens implants. Dr. Goldfarb said common excuses heard by the Board in wrong site surgery were that the nurse prepped the incorrect area, the x-ray department sent the incorrect x-rays and so forth. Dr. Goldfarb said, in the past the Board has not accepted this and has maintained the surgeon is responsible for the pre-operative, operative and post-operative events.

William R. Martin, III, M.D. commented that he agreed with Dr. Goldfarb. He thinks that Board's recent history seems to be deviating for various reasons and would like to establish consistency in all fairness to others. Ram R. Krishna, M.D. said he has been on the Board the longest felt there has been consistency and the only times that has changed is when there have been mitigating factors. Dona Pardo, R.N., Ph.D. said the Board has seen situations where nurses have followed through on an order rather than using the systems of checks and balances, but she agreed that even so, the physician is ultimately responsible for the way the surgery is handled. Timothy Hunter, M.D. noted that in these cases "the devil is in the details."

Christine Cassetta, Board Legal Counsel asked the Board if, since as Dr. Hunter noted, the devil is in the details, they would like to see each of the wrong site/wrong item cases scheduled for Formal Interviews each time to determine if there are any mitigating factors. The Board agreed with Ms. Cassetta's suggestion that the staff no longer make recommendations for Advisory Letters in wrong site surgery cases.

MOTION: Patrick N. Connell, M.D. moved to accept the above summary of responsibilities as the guidelines for surgeons to follow.
SECONDED: William R. Martin, III, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

Preponderance of the Evidence

Christine Cassetta, Board Legal Counsel reminded the Board Members that the standard of proof that they were required to establish when hearing cases was the preponderance of evidence, meaning they must be convinced that, based on the evidence, a fact finding is more likely than not what truly happened or that the existence of a contested fact is more probable than not. Ms. Cassetta explained that the Board does not have to prove a case beyond reasonable doubt or to a standard of clear and convincing.

Creation of Sub-Committee for Drafting a Substantive Policy Statement on Internet Prescribing

Timothy Miller, J.D., Executive Director requested the Board create a sub-committee to draft a substantive policy statement for internet prescribing. Mr. Miller said he would like the sub-committee to further clarify for the public what is and is not allowed of physicians. He also asked the subcommittee to develop something to help patients understand the hazards in obtaining prescriptions over the internet. Ram R. Krishna, M.D. said he felt this was a good suggestion as he believed the legislators and the community at large at large needed education in this area. Robert P. Goldfarb, M.D., FACS stated that he will provide a list of Board members to serve on this subcommittee to the Executive Director.

Board Offsite Meeting Agenda (Friday, September 8, 2006)

Timothy Miller, J.D., Executive Director said he has received several suggestions for topics for the offsite meeting and presented a draft agenda to the Board. Together, the Board members and Staff came up with the following list of suggested topics:

No.	Topic	Suggested By
1.	Board Member Training (formal interviews, consistency, conflicts, etc.)	Christine Cassetta
2.	Post Investigation Process Training (SIRC, post Board meeting, appeals, compliance, Board Order modification)	Bernadette Phelan, Ph.D.
3.	PHP Update (Process and Issues)	Bernadette Phelan, Ph.D.
4.	On-line Testing on State statutes and rules	Bernadette Phelan, Ph.D.
5.	Developing a policy for wrong level/wrong site surgery	Ram R. Krishna, M.D.
6.	Early education for disruptive physicians	Ram R. Krishna, M.D.

7. Creation of subcommittee to communicate PHP to physicians throughout the State — William R. Martin, III, M.D.

8. Implementation of Non-Disciplinary CME — Sharon B. Megdal, M.D.

Approval of Minutes

Dona Pardo, R.N., Ph.D. provided staff with grammatical and typographical changes.

MOTION: Patrick N. Connell, M.D. moved to approve the April 5-6, 2006 Regular Session Minutes, Including Executive Session Minutes and the April 21, 2006 Summary Action Meeting Minutes, Including Executive Session Minutes.
SECONDED: Douglas D. Lee, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

ADVISORY LETTERS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-05-0099A	D.E.	WAHID IBRAHIM, M.D.	30413	Advisory Letter for failure to follow up with a patient and failure to cooperate with the Board's investigation.

Dean Brekke, Assistant Attorney General summarized the case for the Board. Mr. Brekke said Wahid Ibrahim, M.D. was currently unable to practice as he was under a summary suspension. Mr. Brekke also informed the Board that Dr. Ibrahim was not located in the United States. Mr. Brekke said there was another case regarding Dr. Ibrahim that recently went before the Office of Administrative Hearings and the Administrative Law Judge recommended revocation.

MOTION: Patrick N. Connell, M.D. moved to issue an Advisory Letter for failure to follow up with a patient and failure to cooperate with the Board's investigation.
SECONDED: Tim B. Hunter, M.D.
VOTE: 7-yay, 5-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-05-0674A	CHANDLER REGIONAL	RODNEY A. STEWART, M.D.	27962	Issue an Advisory Letter for failure to timely complete medical records.

Vicki Johansen, Senior Medical Investigator summarized the case for the Board. Ms. Johansen said Rodney Stewart, M.D. was reported by his employer as having 300 incomplete charts; however, Ms. Johansen was unable to obtain the charts to determine in what way they were incomplete.

Tim B. Hunter, M.D. noted the term "incomplete" is a broad term and could simply mean Dr. Stewart failed to sign the record. Patrick N. Connell, M.D. noted that while there was sufficient evidence to issue an Advisory Letter, a disciplinary action would be inappropriate since there was evidence lacking as to the severity of the incomplete records.

MOTION: Tim B. Hunter, M.D. moved to issue an Advisory Letter for failure to timely complete medical records.
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-05-0623A	AMB	ZELALEM YILMA, M.D.	25431	Invite the physician for a Formal Interview.

Mr. Stephen Meyers was present and spoke on behalf of Zelalem Yilma, M.D. during the call to the public. Mr. Meyers said the Board's Outside Medical Consultant found that Dr. Yilma only achieved 75% of the the patient's (MC's) heart rate during the treadmill stress test and, therefore, it was incomplete. Mr. Meyers said the Board takes issue that Dr. Yilma stated in her records patient MC's stress test was "completed". Mr. Meyers said the stress test was terminated due to leg pain MC developed during the test and, therefore, the test was complete at that point. Mr. Meyers said he submitted written opinions from four board certified cardiologists who stated Dr. Yilma did not deviate from the standard of care.

Zelalem Yilma, M.D. was present and spoke during the call to the public. Dr. Yilma said she did not believe the stress test could be annulled just because MC did not reach the intended heart rate. Dr. Yilma said she felt her case was not thoroughly investigated because she felt, after the Outside Medical Consultant determined the stress test could not be substantiated, the review ended.

Lorraine Mackstaller, M.D. noted the medical record showed the stress test was stopped due to MC's fatigue and leg pain, and Dr. Mackstaller said she was concerned the stress test may have actually been positive and not negative as reported by Dr. Yilma.

MOTION: Lorraine Mackstaller, M.D. moved to invite the physician for a Formal Interview.
SECONDED: Tim B. Hunter, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent

MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-05-0092A	AMB	WILLIAM M. WOLF, M.D.	17077	Advisory Letter for placing a suture in the bowel during a hernia repair. This was a minor technical violation.

William M. Wolf, M.D. was present without counsel and spoke during the call to the public. Dr. Wolf said a bowel injury is a recognized injury during a hernia repair and that the Board has consistently chosen to dismiss similar cases to this one in the past. Dr. Wolf said following hernia repair, the patient presented with a very benign injury and was not seen as urgent by the internist. Because of this, the internist did not feel the need to immediately contact Dr. Wolf. Dr. Wolf said he was not able to correct the patient's injury until it was too late due to the patient's benign presentation and course.

Dr. Goldfarb noted Dr. Wolf was a Board Medical Consultant and asked if any Board Member felt this would impact his or her ability to review this matter. No Board Member so indicated. Paul M. Petelin, Sr., M.D. noted a death of this circumstance was very rare, but that one of the criteria required post operatively is that any complications are recognized and treated appropriately. Dr. Petelin found it mitigating that Dr. Wolf was not called the night the patient presented with a bowel obstruction and, therefore, did not have the opportunity to respond immediately. Dr. Petelin noted that the patient was 87-years old and had been vomiting when he presented post operatively. Dr. Petelin said these factors alone should have made it clear the patient needed to be seen by Dr. Wolf and not by Dr. Wolf's physician assistant or other healthcare provider. Dr. Petelin said he did understand how it was initially thought the patient was having side effects of the medication and, therefore, greater weight was not placed on the patient's symptoms.

Dr. Petelin said injury to the bowel is a known complication of hernia repair, but it is not a minor complication. Dr. Petelin found the patient did not show the usual signs of injury as the patient was still having bowel movements, which made his presentation more complicated. Dr. Petelin also noted Dr. Wolf was not afforded the luxury of time to recognize the patient's injury because he was not called regarding the patient earlier. However, Dr. Petelin found this was a routine case that resulted in death and for that reason he said it would be difficult for him to dismiss the case.

Ram R. Krishna, M.D. noted peritonitis was seen post operatively in the patient and that it could not have come exclusively from Dr. Wolf's hernia repair as it would have been too soon for peritonitis to have developed. Dr. Krishna found the patient's peritonitis was most likely a pre-existing problem that was perhaps coincidental in that it was noticed post operatively.

MOTION: Ram R. Krishna, M.D. moved to issue an Advisory Letter for placing a suture in the bowel during a hernia repair. This was a minor technical violation.
SECONDED: Sharon B. Megdal, Ph.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-05-1026A	AMB	DANIEL D. MAKI, M.D.	28225	Advisory Letter for misreading a CT Scan.

Sharon B. Megdal, Ph.D. pulled this case for discussion and expressed her agreement with the recommended Advisory Letter.

MOTION: Sharon B. Megdal, Ph.D. moved to issue an Advisory Letter for misreading a CT Scan.
SECONDED: William R. Martin, III, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-05-0989A	D.L.	MICHAEL CHASIN, M.D.	8082	Dismiss

Ms. Jennifer Axel, legal counsel spoke on behalf of Michael Chasin, M.D. during the call to the public. Ms. Axel said this case had a significant mitigating factor in that the patient did not follow up with Dr. Chasin or do anything to correct her illness for nearly three years.

Lorraine Mackstaller, M.D. noted it was SIRC's recommendation that an Advisory Letter be issued because Dr. Chasin failed to inform the patient or the patient's primary care physician of triglycerides in excess of 1000. However, Dr. Mackstaller said she did not believe Urologists monitor triglycerides and because Dr. Chasin is an urologist, Dr. Mackstaller recommended dismissal.

MOTION: Lorraine Mackstaller, M.D. moved to Dismiss the case.
SECONDED: William R. Martin, III, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-05-0256A	AMB	STEPHEN DICKSTEIN, M.D.	6882	Advisory Letter for failure to appropriately evaluate a patient with gross hematuria.

Robert P. Goldfarb, M.D. said he knows Stephen Dickstein, M.D. but it will not affect his ability to adjudicate the case.
Sharon B. Megdal, Ph.D. recused herself from the case.

MOTION: William R. Martin, III, M.D. moved to issue an Advisory Letter for failure to appropriately evaluate a patient with gross hematuria.
SECONDED: Douglas D. Lee, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 2-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-04-0625A	AMB	REBECCA L. HULETT, M.D.	19557	Advisory Letter for inappropriate guide wire placement.

Lorraine Mackstaller, M.D. and Tim B. Hunter, M.D. recused themselves from this case.

MOTION: Douglas D. Lee, M.D. moved to invite the physician for a Formal Interview.
SECONDED: William R. Martin, III, M.D.
VOTE: 2-yay, 8-nay, 0-abstain, 2-recuse, 0-absent
MOTION PASSED.

Paul M. Petelin, Sr., M.D. said it the surgeon was responsible for ensuring the guide wire was in the correct location prior to proceeding with the surgery. Dr. Petelin said this case seemed to demonstrate a communication failure between surgeon and radiologist who placed the guide wire. Paul M. Petelin, Sr., M.D. said the standard of care is that the guide wire is placed one centimeter from the mass to be removed.

William Wolf, M.D., Medical Consultant said that Staff has not been able to obtain a film that has shown the exact distance of the guide wire placement. Ram R. Krishna, M.D. said it is possible for the guide wire to sometimes shift when the patient is being moved.

MOTION: Sharon B. Megdal, Ph.D. moved to issue an Advisory Letter for inappropriate guide wire placement.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 6-yay, 4-nay, 0-abstain, 2-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-05-1094A	AMB	ROBERT M. OSIPOV, M.D.	72895	Offer a Consent Agreement for a Letter of Reprimand for failure to report to the Board his arrest for an act of moral turpitude. If the physician refuses the Consent Agreement, invite for a Formal Interview.

Sharon B. Megdal, Ph.D. said although there was no patient harm in this case, there was an act of moral turpitude committed and that was a sufficient reason to issue disciplinary action. Dona Pardo, R.N., Ph.D. said the Board issued a Letter of Reprimand in the past for a similar case.

MOTION: Dona Pardo, R.N., Ph.D. moved to offer a Proposed Consent Agreement for a Letter of Reprimand for failure to report to the Board his arrest for an act of moral turpitude. If the physician refuses the Consent Agreement, invite for a Formal Interview.
SECONDED: Sharon B. Megdal, Ph.D.
VOTE: 11-yay, 1-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
10.	MD-05-0403A	D.L.	JOSEPH CERJAN, M.D	22609	Advisory Letter for failure to obtain ophthalmology consultation for a patient with a detached retina.

MOTION: Sharon B. Megdal, Ph.D. moved to issue an Advisory Letter for failure to obtain ophthalmology consultation for a patient with a detached retina.
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
11.	MD-05-0444A	AMB	BERND JACOB, M.D.	10119	Advisory Letter for leaving a sponge in a surgical wound.
12.	MD-05-0209A	AMB	CHARLES M.T. JOST, M.D.	28064	Advisory Letter for inadequate medical records.
13.	MD-05-0916A	R.M.	STEVEN R. OTTO, M.D.	13323	Advisory Letter for failure to maintain medical records pursuant to statute.
14.	MD-05-0440A	AMB	RALPH V. WILSON, M.D.	5877	Advisory Letter for failure to preserve the medial nerve during carpal tunnel surgery.
15.	MD-05-0390A	R.T.	JOHN N. GLOVER, M.D.	8971	Invite the physician for a Formal Interview.

R.T. was present and spoke during the call to the public. R.T. said her father was a patient of John Glover, M.D. R.T. alleged Dr. Glover failed to diagnose Valley Fever in her father, resulting in his death. R.T. said Dr. Glover spent three months merely watching a pleural effusion her father had on his lung and did not place her father on any medications. R.T. said that when a later x-ray reviewed the effusion had worsened and a new effusion had appeared, Dr. Glover still took no action for the patient despite loss of weight, difficulty breathing and other worsening and developing symptoms. R.T. said her family took her father to another physician who immediately suspected and diagnosed Valley Fever.

R.T. said, however, at that point it was too later for her father to benefit from treatment, and he subsequently died. R.T. alleged Dr. Glover minimized the severity of her father's condition to the family and led them to believe he was stable and was being adequately cared for. R.T. said she found it egregious that Dr. Glover would not recognize Valley Fever after 30 years of practice.

John Glover, M.D. was present and spoke during the call to the public. Dr. Glover alleged the family did not notify him of the patient's increasing symptoms and often the family pushed scheduled appointments out to further dates. Dr. Glover said he did not believe the patient's weight loss to be significant as he said the loss of weight brought the patient down to his ideal body weight. Dr. Glover also gave statistics of acceptable weight loss rate and said the patient fell within those parameters. Dr. Glover also said loss of weight was normal in the elderly, despite disease. Dr. Glover said he did not believe he committed a cognitive error and alleged the patient's Valley Fever occurred after the patient left his practice.

Lorraine Mackstaller, M.D. said if a patient is losing weight, the physician should determine the cause of the weight loss. Tim B. Hunter, M.D. said he had never heard the weight loss figures Dr. Glover presented in argument to the Board and felt there was a need for the Board to further question Dr. Glover.

MOTION: Lorraine Mackstaller, M.D. moved to invite the physician for a Formal Interview.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
16.	MD-05-0277A	AMB	JOHN W. HOWLEY, M.D.	22390	Advisory Letter for stating he was board certified in cardiology when his certification had expired and in fact he was only board eligible.

MOTION: Lorraine Mackstaller, M.D. moved to issue Advisory Letters for items 11, 12, 14, and 16.
SECONDED: Douglas D. Lee, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
17.	MD-05-0473A	AMB	RAUL A. OSORIO, M.D.	11226	Advisory Letter for failure to appropriately manage the anti-coagulation status of a patient post-operatively.

MOTION: Sharon B. Megdal, Ph.D. moved to issue advisory letters for items 13 and 17.
SECONDED: William R. Martin, III, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
18.	MD-05-0785A	AMB	CARLOS A. CARRION, M.D.	5752	Invite the physician for a Formal Interview.

MOTION: Sharon B. Megdal, Ph.D. moved to invite the physician for a Formal Interview.
SECONDED: Douglas D. Lee, M.D.
VOTE: 11-yay, 0-nay, 0-abstain, 1-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
19.	MD-05-0770A	AMB	RICHARD C. ROTHMAN, M.D.	29754	Offer a Proposed Consent Agreement for a Letter of Reprimand for implanting the wrong lens in a patient and if the physician refuses, invite him for a Formal Interview.

MOTION: Patrick N. Connell, M.D. moved to offer the physician a Consent Agreement for a Letter of Reprimand for implanting the wrong lens in a patient and if the physician refuses, invite him for a Formal Interview.
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
20.	MD-03-0014A	AMB	ZEV FAINSILBER, M.D.	22634	Invite the physician for a Formal Interview.

Kathleen Muller, Physician Health Program Manager summarized the recommendation from a psychologist stating Zev Fainsilber, M.D. should obtain a chaperone to accompany him when seeing patients, not because Dr. Fainsilber was untrustworthy, but mainly to protect Dr. Fainsilber from future allegations.

Douglas D. Lee, M.D. said he felt a chaperone was recommended to possibly also protect the patient. Tim B. Hunter, M.D. said it may be helpful for the Board to engage in discussion with Dr. Fainsilber.

MOTION: Tim B. Hunter, M.D. moved to invite the physician for a Formal Interview.
SECONDED: William R. Martin, III, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

APPEAL OF ED DISMISSALS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-04-0005A	E.V.	STEVEN M. GITT, M.D.	17134	Uphold the Executive Director's Dismissal.

Victoria Kamm, Senior Medical Investigator said that in the appeal, the complainant did not provide any new information about complaint that had not already been reviewed by Board Staff. Ms. Kamm said the complainant alleged the investigation was compromised due to the turnover of investigators. Ms. Kamm said she was the new investigator and testified she had reviewed all of the records for the case and the investigation was not compromised in any way.

MOTION: Tim B. Hunter, M.D. moved to uphold the Executive Director's Dismissal.
SECONDED: Becky Jordan
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-04-0117A	AMB	JOGESWAR RATH, M.D.	10077	Uphold the Executive Director's Dismissal.

Timothy Miller, J.D., Executive Director explained the path of this case. Mr. Miller said the case was originally going to be brought to the Board as a Formal Interview, however, it was discovered the case was originally placed on the agenda as an appeal of an Executive Director dismissal. The Board requested further investigation. The investigation did not reveal any new information and, therefore, Staff placed the matter back on the Board's agenda for an appeal of an Executive Director dismissal.

Ingrid Haas, Medical Consultant summarized the case for the Board and stated the Outside Medical Consultant did not find a deviation from the standard of care.

MOTION: Ram R. Krishna, M.D. moved to uphold the Executive Director's Dismissal.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

OTHER BUSINESS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-05-0999A	P.L.	WILLIAM S. MASLAND, M.D.	6352	Accept Proposed Consent Agreement for a Letter of Reprimand for improper treatment of chronic pain and improper dosing of methadone.

Robert P. Goldfarb, M.D. and Ram R. Krishna, M.D. said they know William Masland, M.D. but it will not affect their ability to adjudicate the case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-03-1026A	AMB	CHARLES A. BOLLMANN, M.D.	6020	Accept Proposed Consent Agreement for a Letter of Reprimand for allowing an unlicensed aesthetician to perform procedures on patients.
3.	MD-05-1085A	AMB	THOMAS BRANDT, M.D.	25293	Reject the Consent Agreement for a 5 year Probation and offer a Consent Agreement for a Letter of Reprimand for performing surgery while intoxicated and a 5 year Probation for participation in the Monitored Aftercare Program.

Dona Pardo, R.N., Ph.D. noted Thomas Brandt, M.D. failed to report a Driving Under the Influence (DUI) conviction and said she was not sure a 5 year Probation was a sufficient discipline. Christine Cassetta, Board Legal Counsel, reviewed the Board's previously adopted position for handling a non-reporting of a DUI.

Paul M. Petelin, Sr., M.D. noted there was also potential patient harm in this case because Dr. Brandt performed a surgery and was then arrested on his drive home. Tim B. Hunter, M.D. said he felt more should be done in the way of disciplinary action as Dr. Brandt performed a procedure of a significant nature on a patient while he was more likely than not impaired.

MOTION: Tim B. Hunter, M.D. moved to reject the Consent Agreement for a 5 year Probation and offer a Consent Agreement for a Letter of Reprimand and a 5 year Probation for participation in the Monitored Aftercare Program.
SECONDED: Ram R. Krishna, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N.,Ph.D and Paul M. Petelin, Sr., M.D. The following Board Member was not present: Patricia R.J. Griffen
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-05-0242A	AMB	JOHN W. HOWLEY, M.D.	22390	Accept the Proposed Consent Agreement for a Letter of Reprimand for violating a Board Order and a 5 Year Probation for participation in the Monitored Aftercare Program.

Douglas D. Lee, M.D. recused himself from this case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-05-0829A	V.O.	BEATRICE YANG, M.D.	25741	Accept the Proposed Consent Agreement for a Letter of Reprimand for failing or refusing to maintain adequate medical records on a patient.
6.	MD-05-0063A	AMB	SUZANNE E. MUNNS, M.D.	20007	Accept the Proposed Consent Agreement for a Letter of Reprimand for violating a Board Order and a 5 year Probation for participation in the Monitored Aftercare Program.
7.	MD-05-0457A	V.M.	MARC H. ZIMMERMAN, M.D.	14797	Accept the Proposed Consent Agreement for a Letter of Reprimand for performing a wrong site surgery.
8.	MD-04-0588B	AMB	HENRY REUSS, M.D.	3516	Accept the Proposed Consent Agreement for a Letter of Reprimand for improper repair of an episiotomy resulting in patient harm.

Patricia R.J. Griffen recused herself from the case.

9.	MD-04-0475A	AMB	INAYAT ALI-KHAN, M.D.	12985	Accept the Proposed Consent Agreement for a Letter of Reprimand for inadequate record keeping and 2 Year Probation to include completion of the Physician Assessment and Clinical Evaluation (PACE) and to receive a random chart review after completion of the CME.
10.	MD-05-1205A	P.R.	MARY E. GROVES, M.D.	30315	Accept the Proposed Consent Agreement for a Decree of Censure for failure to appropriately close her practice and distribute medical records to patients, failure to make reasonable accommodation for medical records, and failure to retain records for the time required by law.
11.	MD-04-0333A	AMB	MARY E. GROVES, M.D.	30315	Accept the Proposed Consent Agreement for Suspension.

12.	MD-03-0174A	H.W.	JOHN E. HENSLER, M.D.	5346	Accept the Findings of Fact, Conclusions of Law and Order for a Decree of Censure for inappropriate billing, inadequate medical records, mismanagement of an addicted patient and failure to diagnose and treat pneumonia in a timely fashion contributing to the death of a patient. Probation for 2 years to obtain 20 hours of Continuing Medical Education (CME) in record keeping, billing and coding, to have a random chart review, complete Physician Assessment and Clinical Evaluation (PACE) and to pay, within 60 days, a civil penalty in the amount of $5,000.
13.	MD-04-0549A	J.F.	DONOVAN J. ANDERSON, M.D.	13491	Accept the Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for improperly disposing of medical records.
14.	MD-04-0991A	R.M.	MILUSE VITKOVA, M.D.	20176	Accept the Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failing or refusing to maintain adequate records, specifically amending an autopsy report without indicating it was amended.

15.	MD-05-0054A	AMB	GERALD TELEP, M.D.	12749	Accept the Findings of Fact, Conclusions of Law and Order for a 2 year Probation for participation in the Monitored Aftercare Program.
16.	MD-05-0151A	AMB	JERI B. HASSMAN, M.D.	16132	Accept the Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for excessive joint and soft tissue injections without adequate indications and for inadequate documentation of the quantities of the pharmaceuticals injected. Two (2) year Probation for practice restriction from performing joint and soft tissue injections.

Robert P. Goldfarb, M.D. said he knows Jeri Hassman, M.D. but it will not affect his ability to adjudicate the case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
17.	MD-05-0884A	MCSO	HARSHAD PATEL, M.D.	22757	Accept the Findings of Fact, Conclusions of Law and Order for a Decree of Censure for failing to properly conduct an examination for vaginitis and for engaging in sexual conduct with a patient. Probation for 5 years restricted to seeing only male patients and must have a chaperone present for each patient visit and must work no more than 30 hours per week. Shall undergo therapy and professional evaluation and shall follow those recommendations given from therapy and evaluation.
18.	MD-05-1033A	AMB	MICHAEL HERION, M.D.	30486	Accept the Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for prescribing over the internet without conducting a physical examination or having previously established a doctor patient relationship and for failing to maintain adequate medical records.

MOTION: Patrick N. Connell, M.D. moved to accept the Findings of Fact, Conclusions of Law and Order for items 12, 13, 14, 15, 16, 17 and 18.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
19.	MD-04-L131A	AMB	MARTHAELENA CORRAL, M.D.	25882	Uphold the ED Denial of Licensure

Marlene Young, Senior Medical Investigator summarized the case for the Board. Ms. Young said Marthaelena Corral, M.D. was previously under a Board Order requiring that she practice in a group setting. Dr. Corral violated the terms of her Order and her license later expired. The Order was stayed until which time she re-applies for a license. Ms. Young said the Executive Director denied Dr. Corral's application. Ms. Young said that in the interim, Dr. Corral has not been practicing medicine, but has been teaching school for children. SIRC recommended denial of re-licensure based on the psychiatric evaluation with Michael Brennan, M.D.

Kathleen Muller, Physician Health Program Manager summarized the psychiatric evaluation from Dr. Brennan stating he felt Dr. Corral had benefited from therapy and would be able to avoid interpersonal conflict.

Tim B. Hunter, M.D. noted Dr. Corral has been out of practice for a long period of time and had not kept current on her continuing medical education (CME). Patrick N. Connell, M.D. noted Dr. Brennan did not say Dr. Corral was unfit to practice medicine, but that in fact she may be fine practicing in a correctional setting. Christine Cassetta, Board Legal Counsel said she interpreted that notation by Dr. Brennan to mean Dr. Corral would not be able to engage in a full, unlimited practice setting. Ms. Cassetta also noted that Dr. Corral's original problems with the Board surfaced when she was working within the prison environment. Dr. Hunter said it seems Dr. Corral is asking the Board to grant her license and yet does not have a game plan to show the Board what she has done to show she should be given a license.

MOTION: William R. Martin, III, M.D. moved to deny the license based on A.R.S. §32-1422 (A) An applicant for a license to practice medicine in this state pursuant to this article shall meet each of the following basic requirements: A.R.S. §32-1422 (3)- Have the physical and mental capability to safely engage in the practice of medicine, A.R.S. §32-1422 (4)- Have a professional record which indicates that the applicant has not committed any act or engaged in any conduct which would constitute grounds for disciplinary action against a licensee under this chapter, A.R.S. §32-1422 (C)- In determining if the requirements of subsection A, paragraph 4 have been met, if the board finds that the applicant committed an act or engaged in conduct that would constitute grounds for disciplinary action, the board shall determine to its satisfaction that the conduct has been corrected, monitored and resolved. If the matter has not been resolved, the board shall determine to its satisfaction that mitigating circumstances exist which prevent its resolution, and A.R.S. §32-1422 (D) In determining if the requirements of subsection A, paragraph 6, have been met, if another jurisdiction has taken disciplinary action against an applicant, the board shall determine to its satisfaction that the cause for the action was corrected and the matter resolved. If the matter has not been resolved by that jurisdiction, the board shall determine to its satisfaction that mitigating circumstances exist which prevent its resolution.
SECONDED: Douglas D. Lee, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 1-absent

MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
20.	MD-05-L190A	AMB	STEVEN L. SUFFECOOL, M.D.	11240	Uphold the ED Denial of Licensure

Robert P. Goldfarb, M.D. said he knows Steven Suffecool, M.D. but it would not affect his ability to adjudicate the case.
Dona Pardo, R.N., Ph.D. recused herself from the case.

Steven Suffecool, M.D. was present and spoke during the call to the public. Dr. Suffecool said he was appealing his denial of license. Dr. Suffecool said he will have three years of sobriety this August, has learned from his errors and would like to return to practice. Dr. Suffecool said he recognizes it would be a danger to his health to return to the practice of anesthesia and so he would rather chose to practice psychiatry or addiction medicine.

Lorraine Brown, Senior Compliance Officer summarized the case to the Board. Ms. Brown said Dr. Suffecool entered into a Stipulated Rehabilitation Agreement with the Board in 1986 for the use of alcohol or habitual substance. He subsequently relapsed two times following that Order and his license was Cancelled with Cause on January 25, 1997 for chemical dependency. Michel Sucher, M.D., privately monitored Dr. Suffecool since December 2003 and said he had been compliant with the monitoring and Dr. Sucher recommended he be granted an Arizona license. However, the Physician Health Program (PHP) staff had concerns as Dr. Suffecool's evaluation stated his likelihood for relapse is moderate to high, and the PHP Staff noted Dr. Suffecool has never attended long-term inpatient treatment.

MOTION: William R. Martin, III, M.D. moved to deny the license based on A.R.S. §32-1422 (A) An applicant for a license to practice medicine in this state pursuant to this article shall meet each of the following basic requirements: A.R.S. §32-1422 (3)- Have the physical and mental capability to safely engage in the practice of medicine, and A.R.S. §32-1422 (C)- In determining if the requirements of subsection A, paragraph 4 have been met, if the board finds that the applicant committed an act or engaged in conduct that would constitute grounds for disciplinary action, the board shall determine to its satisfaction that the conduct has been corrected, monitored and resolved. If the matter has not been resolved, the board shall determine to its satisfaction that mitigating circumstances exist which prevent its resolution.
SECONDED: Patrick N. Connell, M.D.

William R. Martin, III, M.D. spoke in favor of the motion noting Dr. Suffecool did not stay current on his Continuing Medical Education during the time he was not practicing and he also had not had any patient contact in nine years. Patrick N. Connell, M.D. spoke in favor of denying the license stating Dr. Suffecool had relapse multiple times and have never received long-term treatment.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., The following Board Member was recused: Dona Pardo, R.N., Ph.D., The following Board Member abstained: Paul M. Petelin, Sr., M.D. , The following Board Member was absent: Patricia R.J. Griffen
VOTE: 9-yay, 0-nay, 1-abstain, 1-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
21.	MD-03-1046A	R.L.	JOHN V. DOMMISSE, M.D.	22164	Uphold the Executive Director referral to Formal Hearing for Revocation.

John Dommisse, M.D. was present and spoke during the call to the public. Dr. Dommisse said he preferred to have his case be heard before the Administrative Law Judge as he did not want to be judged by physicians who did not practice nutritional medicine. He said there has been one physician who has made three complaints against him in his 40 years of practice, and feels he is being unjustly targeted by a physician who does not understand his nutritional medicine approach.

Kelly Sems, M.D., Internal Medical Consultant said Dr. Dommisse is under a Decree of Censure and 5 Year Probation for violation of a Board Order and was required to submit for a Physician Assessment and Clinical Evaluation (PACE). The current case (MD-03-1046A) came to the attention of the Board when a patient alleged Dr. Dommisse improperly prescribed thyroid medication and refused to forward her medical records to another treating physician. As a result of this case, a chart review was done and multiple deviations were discovered specifically documentation issues, improper encounters for office visits, treatment for conditions without conducting a physical examination, a questionable relationship with a laboratory where lab values were altered, altering lab values himself and inappropriate laboratory tests relative to the diagnosis. SIRC found that it appeared Dr. Dommisse showed a complete disregard for the Board's Order he was currently under as he had not changed his practice since receiving the disciplinary action. Mark Nanney, M.D., Chief Medical Consultant stated Dr. Dommisse also has refused to submit to PACE as ordered.

Lorraine Mackstaller, M.D. noted Dr. Dommisse said he wanted to be reviewed by a peer, but since he is not board certified in any specialty it would be unclear what type of peer he would like to be reviewed by.

The Board went into Executive Session 4:15 p.m.
The Board returned to Open Session at 4:19 p.m.

Dean Brekke, Assistant Attorney General, corrected a previous assumption that Dr. Dommisse did not submit for the Physician Assessment and Clinical Evaluation (PACE) and informed the Board that Dr. Dommisse did complete the evaluation and PACE did not find any major deficiencies in his fund of knowledge.

MOTION: Ram R. Krishna, M.D. moved to uphold the Executive Director referral to Formal Hearing for Revocation.
SECONDED: William R. Martin, III, M.D.

Tim B. Hunter, M.D. asked Staff if the care in the current case was rendered before or after the Board's last action. Christine Cassetta, Board Legal Counsel said this case was opened because of new issues discovered upon chart review and the deficiencies occurred after the Board issued disciplinary action.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D. and Paul M. Petelin, Sr., M.D., The following Board Member was absent: Patricia R.J. Griffen
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
22.	MD-04-0859A	AMB	ROY R. GETTEL, M.D.	11015	Deny request for Modification of Board Order.

Robert P. Goldfarb, M.D. said he knows Roy Gettel, M.D. but it would not affect his ability to adjudicate the case.

Roy R. Gettel, M.D. was present and spoke during the call to the public. Dr. Gettel requested modification of his Board Order to lift the surgical restriction although he said he has no intention of returning to surgery. Dr. Gettel said he felt the disciplinary action was excessive as he has been dropped by several insurance carries and his practice has suffered. Dr. Gettel said he has since taken courses to improve his knowledge base of ankle surgeries.

Gerald Moczynski, M.D., Medical Consultant summarized the request for modification of Board Order and noted Dr. Gettel's request to the Board shows he continues to lack insight into his substandard care that prompted the Board's disciplinary action.

MOTION: Sharon B. Megdal, Ph.D. moved to deny the request for Modification of Board Order.
SECONDED: Patrick N. Connell, M.D.

Sharon B. Megdal, Ph.D. said there was a reason the Board decided on the original disciplinary action and that they have not been shown there is any reason to change that original decision.

William R. Martin, III, M.D. said Dr. Gettel's testimony seemed to show he did not understand that his Board Order restricts him from performing all surgery and that the restriction is not only for ankle surgery.

VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
23.	MD-03-0414A	AMB	JAMES T. CANAVAN, M.D.	19964	Modify Board Order to grant prescribing privileges.

Kathleen Muller, Physician Health Program Manager summarized case. Ms. Muller said James Canavan, M.D. has successfully participated for two years in the Physician Health Program and is in compliance with the Consent Agreement.

MOTION: Lorraine Mackstaller, M.D. moved to grant the request for Modification of Board Order to grant prescribing privileges.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
24.	MD-04-1504A	AMB	MAZEN H. KHAYATA, M.D.	20382	Deny the request for Rehearing or Review

Jennifer Axel, legal counsel spoke on behalf of Mazen Khayata, M.D. Ms. Axel said Dr. Khayata did not instruct that fresh frozen plasma be administered to the patient within two hours, and it is not within his practice to do so. Ms. Axel also said the events in this case were a one time occurrence and therefore the action taken by the Board was excessive.

Dean Brekke, Assistant Attorney General directed the Board to his confidential legal memo in their materials.

MOTION: Sharon B. Megdal, Ph.D. moved to deny the request for Rehearing or Review.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
25.	MD-04-0173A	AMB	SHAHID P. MALIK, M.D.	31690	Deny the request for Rehearing or Review

Dean Brekke, Assistant Attorney General summarized the motion for rehearing as submitted by Shahid Malik, M.D. Mr. Brekke said Dr. Malik said he believed he fell within the exemption of the statute for physicians covering for another physician. However, Mr. Brekke said it was his position that the petition be denied.

MOTION: Ram R. Krishna, M.D. moved to deny the request for rehearing or review.
SECONDED: Tim B. Hunter, M.D.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
26.	MD-06-0375A	AMB	MICHAEL S. BISCOE, M.D.	20915	Accept the Proposed Consent Agreement for license reactivation upon payment of the renewal fee and a 5 year Probation for participation in the Monitored Aftercare Program.

Patrick N. Connell, M.D. said he knows Michael Biscoe, M.D. but it will not affect his ability to adjudicate the case.
William R. Martin, III, M.D. recused himself from the case.

Michael Biscoe, M.D. was present and spoke during the call to the public. Dr. Biscoe said he felt his treatment at Betty Ford was helpful, he takes responsibility for his actions and is actively working his recovery program. Dr. Biscoe asked the Board to grant him the privilege to return to internal medicine.

MOTION: Douglas D. Lee, M.D. moved to accept the Proposed Consent Agreements for items 1, 2, 4, 5, 6, 7, 8, 9, 10, 11 and 26.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D and Paul M. Petelin, Sr., M.D., The following Board Member was not present: Patricia R.J. Griffen

WEDNESDAY, June 7, 2006

CALL TO ORDER
Robert P. Goldfarb called the meeting to Order at 9:30 a.m.

ROLL CALL
The following Board Members were present: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D and Paul M. Petelin, Sr., M.D.

CALL TO PUBLIC
Patient C.D. was present and spoke during the call to the public. Her case was not on the Board's agenda for consideration. C.D. stated William Mora, M.D. incorrectly bandaged her hand following surgery. She said she was in excruciating pain and when she removed the bandaging after 18 hours her hand was necrotic and as a result her joints were not able to be preserved. C.D. expressed her concern about not being treated appropriately by the previous Arizona Medical Board Staff, but expressed thankfulness that that Dr. Mora's public profile showed disciplinary action had since been taken against Dr. Mora in other cases, and asked action be also taken against Dr. Mora her case as well. C.D. also praised the new Executive Director, Timothy C. Miller, J.D., for the work he has done.

Keith King M.D. was present and spoke during the call to the public. Dr. King's case was not on the Board's agenda for consideration. Dr. King said the Board found discrepancies in 20 of his patient charts that they reviewed and requested he have access to the findings so that he may obtain that information.

All other statements issued during the call to the public will appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-05-0296A	AMB	JOSEPH FRANZETTI, M.D.	26738	Advisory Letter for failing to appropriately document a late entry into the chart.

Joseph Franzetti was present with counsel, Mr. Bryan Murphy.

Kelly Sems, M.D., Medical Consultant summarized the case to the Board. Dr. Sems said the case came to the attention of the Board as the result of a newspaper article stating inmate/patient S.C. committed suicide while under Dr. Franzetti's care. The article also alleged Dr. Franzetti

provided inappropriate supervision for patient S.C. Dr. Sems said the Board's Staff investigation revealed Dr. Franzetti met with S.C. on only two occasions over a nine day period. SIRC found Dr. Franzetti failed to appropriately evaluate a patient with suicidal ideation.

Patrick N. Connell, M.D. led the questioning. Dr. Connell noted S.C. attempted suicide by tying an article of clothing around his throat while in the police car on the way to the hospital. Dr. Connell said that demonstration should have alerted Dr. Franzetti to S.C.'s risk of suicide. Dr. Franzetti said he took this into consideration, but felt the incident was not a serious suicide attempt and was rather a cry for help and a demonstration that he was hurting in some way. Dr. Connell noted that 10 days later S.C. successfully committed suicide using a piece of clothing when he was at his in a holding cell at court.

Dr. Connell noted Dr. Franzetti used physical restraints to keep S.C. safe when he first was admitted to the jail. However, Dr. Connell noted he felt it would have been more humane to use medications to restrain S.C. Dr. Franzetti said he was initially unable to evaluate S.C. and thought physical restraints would be the best way to keep S.C. safe until he arrived since there were no other physicians available at the time.

Dr. Connell noted, on the second time Dr. Franzetti saw S.C., he made a late entry the following day stating S.C. was doing well. Dr. Connell said the late entry was not appropriately marked as a "late" entry and it seemed self-serving that it was written 30 minutes after S.C. committed suicide. Dr. Franzetti said he did not learn of S.C.'s suicide until a later date and he often made late entries in charts due to his work load.

Dr. Connell found Dr. Franzetti did not give adequate supervision to S.C. by seeing him only twice within nine days despite multiple red flags that more thorough care was needed. Dr. Connell said Dr. Franzetti should have been alerted to the severity of S.C.'s suicidal ideation because of S.C.'s two previous suicide attempts, family history of suicide, S.C.'s history of substance abuse, S.C.'s current family issues, and S.C.'s stress of the possibility of facing a long term in prison. Dr. Franzetti said S.C. was seen by a team of professionals that he oversaw, including master's level counselors, lay counselors and registered nurses, and S.C. showed signs he was progressing to all of them.

Robert P. Goldfarb, M.D. noted the system Dr. Franzetti worked under allowed two psychiatrists to care for approximately 80 patient inmates. Dr. Franzetti said he was able to do this by reviewing all patient records each day and supervising the team of professionals who had more frequent contact with the patients.

William R. Martin, III, M.D. said he found Dr. Franzetti's testimony that the medical note that was written 30 minutes after S.C.'s suicide was merely coincidental was not credible. Dr. Franzetti said he had recommended S.C. be moved to the general population and felt no need to follow up after the patient went to court (where he subsequently committed suicide) because he believed he had merely been moved to another section of the facility. Dr. Martin noted the record showed the director of medicine was contacted regarding the suicide and she secured the medical records shortly thereafter. Dr. Martin found it odd that Dr. Franzetti would not be notified why his medical record was being secured or that his patient had died.

Mr. Murphy, legal counsel for Dr. Franzetti said the Board prohibits the prescribing of medication prior to conducting a physical exam. He said, for that reason, physical restraints were appropriately used for S.C. Mr. Murphy said Dr. Franzetti exceeded the standard of care for S.C.

Dr. Connell said he did not believe the same level of care was provided to S.C. as an inmate, as would have occurred in the community setting, in that S.C. only received two brief evaluations from Dr. Franzetti. Dr. Connell said although the suicide could not have been foreseen, it does not excuse that something more in the way of evaluations should have been done for S.C. Dr. Connell said he doubts Dr. Franzetti's testimony about not knowing about S.C.'s suicide at the time of his late entry in the chart, as the chart was secured only 30 minutes later by the administration. Dr. Connell found fault that Dr. Franzetti did not indicate he had made a late entry in the medical record.

MOTION: Patrick N. Connell, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(e)- Failing or refusing to maintain adequate records on a patient.
SECONDED: William R. Martin, III, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

Dr. Connell noted Dr. Franzetti seemed to be complacent the care he provided S.C., however, Dr. Connell noted he found Dr. Franzetti's care in this case appalling.

Sharon B. Megdal, Ph.D. said she was going to abstain from the case because she felt the Board was leaning toward this case being a record issue and she did not feel Dr. Franzetti was being dishonest about his late entry. Dona Pardo, R.N., Ph.D. said she agreed with Dr. Megdal and was also going to abstain for the reasons mentioned by Dr. Megdal.

Lorraine Mackstaller, M.D. said she had some experience working in jail environment during medical school and found the intensity of work load was beyond comprehension. Dr. Mackstaller said she felt it was appropriate that S.C. was being evaluated by a team and thought the deviation in this case was more based on a record issue.

MOTION: Patrick N. Connell, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: William R. Martin, III, M.D.
VOTE: 4-yay, 6-nay, 2-abstain/recuse, 0-absent
MOTION FAILED.

MOTION: Patrick N. Connell, M.D. moved to issue an Advisory Letter for failing to appropriately document a late entry into the chart.
SECONDED: Robert P. Goldfarb, M.D.

William R. Martin, III, M.D. spoke against the motion stating he believed Dr. Franzetti's testimony concerning the late entry was not forthright.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D and Paul M. Petelin, Sr., M.D., The following Board members voted against the motion: Patrick N. Connell, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D.
VOTE: 9-yay, 3-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-05-0514A	AMB	PAUL SAIZ, M.D.	25767	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for performing a surgery that did not address the patient's problem requiring a second surgery, since the surgery was not performed at the site that was originally planned.

Paul Saiz, M.D. was present with counsel Mr. Stephen W. Myers.

William R. Martin, III, M.D. and Douglas D. Lee, M.D. recused themselves from the case.

Gerald Moczynski, M.D., Internal Medical Consultant summarized the case for the Board. Dr. Moczynski said wrong level surgery was sustained in this case. Dr. Moczynski said Dr. Saiz confirmed the correct level of surgery prior to the operation, however, the post surgical note showed he did not decompress the level he intended to. The Internal Medical Consultant found this was in error and required the patient to undergo a second surgery to decompress.

Dr. Saiz said he did not become lost during the operation and did not perform a wrong level surgery. Dr. Saiz said, rather, the surgery differed from his preoperative plan to fuse and decompress the level above the patient's previous surgical site, because once he began the operation he made a new finding and chose to address the pain generators that he believed fell within the consent form. Dr. Saiz said that after his first surgery for the patient, her leg pain improved. Dr. Saiz said he believes the patient would have still required subsequent surgery following his procedure even if he had followed his preoperative plan.

The x-rays from the case were available and were reviewed by the Board during the meeting. Ram R. Krishna, M.D. led the questioning and noted Dr. Saiz did not have the patient's prior MRI from the evaluation by a neurosurgeon and that it should have been obtained prior to the first surgery he performed. Dr. Krishna said it did not seem appropriate that Dr. Saiz did not fuse the level intended in his pre-operative plan. Dr. Krishna found the medical record did show Dr. Saiz did have the appropriate consent because he discussed the procedure with the family.

Dr. Goldfarb drew a diagram for the Board demonstrating his theory that because the patient had metal plates in her spine, it would be difficult for a physician to become lost during the operation because he could use the metal plates as reference points. Dr. Goldfarb said he felt this made it more egregious that Dr. Saiz performed a wrong level surgery.

Dr. Saiz said in hindsight he realized he had appropriate consent, but at the time he thought he was doing the best thing by being conservative and thought he addressed the most logical pain generators. Dr. Saiz said he did not get lost during the procedure, but made a choice that differed from his preoperative note.

Mr. Meyers said he gathered opinions from experts who agreed Dr. Saiz's care was appropriate. Mr. Meyers said Dr. Saiz handled the care in this case in a logical and straightforward manner and maintained an adequate medical record.

Dr. Krishna said it was unfortunate that the patient had to go back for second surgery and the fact that Dr. Saiz operated a second time on the same patient indicated that he most likely felt he did not thoroughly perform the first procedure. Dr. Krishna said he found Dr. Saiz fell below the standard of care by operating on the wrong level. Dr. Krishna said he found it more egregious that Dr. Saiz had the advantage of the metal plates as a reference point.

MOTION: Ram R. Krishna, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Dona Pardo, R.N., Ph.D.
VOTE: 9-yay, 1-nay, 0-abstain 2-recuse, 0-absent
MOTION PASSED.

Tim B. Hunter, M.D. said he did not believe Dr. Saiz was lost during the procedure, but rather chose not to operate in the location originally indicated. Dr. Hunter said he did not believe this case demonstrated a wrong site surgery, but that he was more concerned with Dr. Saiz's indications for performing surgery.

MOTION: Ram R. Krishna, M.D. moved Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for performing a surgery that did not address the patient's problem requiring a second surgery, since the surgery was not performed on the wrong site.
SECONDED: Dona Pardo, R.N., Ph.D.

Lorraine Mackstaller, M.D. her observation with back surgery has been repeated multiple times.

The Board went into Executive Session 12:59 p.m.
The Board returned to Open Session at 1:04 p.m.

Dr. Hunter asked that the motion be amended to say the surgery was performed at a site not originally planned, requiring subsequent surgery.

Robert P. Goldfarb, M.D. spoke against the recommendation for amendment stating he felt the physician's testimony and the evidence showed Dr. Saiz went into the surgery with the plan to fuse and decompress the level above the previous surgical site. Dr. Hunter said he believed the physician's testimony was that he chose not to operate at the level above the previous surgical site.

MOTION: Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for performing a surgery that did not address the patient's problem requiring a second surgery, since the surgery was not performed at the site that was originally planned.
SECONDED: Dona Pardo, R.N., Ph.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D. and Dona Pardo, R.N., Ph.D. The following Board Members voted against the motion: Becky Jordan, Lorraine Mackstaller, M.D., Paul M. Petelin, Sr., M.D., The following Board Member abstained: Patricia R.J. Griffen, The following Board Members were recused: William R. Martin, III, M.D., Douglas D. Lee, M.D.
VOTE: 6-yay, 3-nay, 1-abstain 2-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-04-0501A	AMB	LARRY W. NICHOLS, M.D.	14326	Dismiss

Larry Nichols, M.D. was present with counsel, Mr. Peter Fisher.

Sue Dana, Compliance Officer summarized the case for the Board. Ms. Dana said the case was opened due to Dr. Nichols non-compliance with a Probationary Order for record keeping. Ten charts were reviewed and an Outside Medical Consultant found evidence of inadequate medical records and potential harm in some of the cases. SIRC agreed with the findings and felt Dr. Nichols fell below standard of care in four instances. SIRC found the deviations were not particularly egregious.

Dr. Nichols said he is now proactive and has improved further in his charting and has made significant changes since receiving the Board Order. Dr. Nichols explained the documentation issues in the four cases discussed by the Board and said he simply overlooked documenting. Dr. Nichols said improving his charting has been an ongoing process, but he is doing his best to be compliant with his Board Order.

William R. Martin, III, M.D. led the questioning. Dr. Martin noted that patient L.A. submitted for an industrial complaint, but Dr. Nichols did not completely separate her complaints to keep the industrial injuries apart from the medical illnesses. Dr. Martin also noted Dr. Nichols found the patient was anemic, but he did not determine a reasonable cause for the anemia. Dr. Martin said Dr. Nichols wrote in the chart the patient was not menstruating due to her Depo-Provera shot and also wrote in the same note that her anemia was due to her menses. Dr. Nichols explained that the patient was not menstruating at the time he saw her, but that her Depo-Provera would cause her to bleed for several weeks at a time and could have caused the anemia.

Mr. Fisher, legal counsel for Dr. Nichols said Dr. Nichols has significantly improved his medical records. Mr. Nichols said that there were some documentation cases that could have been improved in 2002 and 2003, but Dr. Nichols has created problem lists and has taken Continuing Medical Education.

Patrick N. Connell, M.D. said the chart in this case were old charts and if staff were to review recent charts they may find Dr. Nichols has indeed improved his charting as everyone's practice evolves and changes with time.

Dr. Martin said he appreciated Dr. Nichol's forthrightness with the Board and acknowledged the Board did not have recent charts of Dr. Nichols' available for review. Dr. Martin found Dr. Nichol's adequately addressed his concerns during his testimony and that the concerns in this case were somewhat dated.

MOTION: William R. Martin, III, M.D. moved to Dismiss the case.
SECONDED: Ram R. Krishna, M.D.

Dona Pardo, R.N., Ph.D. and Douglas D. Lee, M.D. spoke against the motion stating this case originated as a violation of a Board Order and should not be dismissed.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., and Paul M. Petelin, Sr., M.D., The following Board Members voted against the motion: Douglas D. Lee, M.D. and Dona Pardo, R.N., Ph.D.
VOTE: 10-yay, 2-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

CALL TO THE PUBLIC – 1:15 p.m.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-04-0625B	AMB	F. HUGO VILLAR-VALDES, M.D.	9674	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for **performing an inadequate biopsy and for failure to aggressively pursue a repeat biopsy.**

F. Hugo Villar-Valdes, M.D. was present without counsel.

Robert P. Goldfarb, M.D., Tim B. Hunter, M.D. and Lorraine Mackstaller, M.D. recused themselves from the case. Paul M. Petelin, Sr., M.D. and Douglas D. Lee, M.D. said they know Dr. Villar-Valdes, but it would not affect their ability to adjudicate the case. Douglas D. Lee, M.D. said he knows Dr. Villar-Valdes, but it would not affect his ability to adjudicate the case.

William Wolf, M.D., Medical Consultant summarized the case for the Board. A medical malpractice settlement was made on behalf of Dr. Villar-Valdes alleging he failed to remove sufficient tissue at the time of a breast biopsy for patient T.S. resulting in an eight-month delay in diagnosis of breast cancer and metastatic disease. It was also alleged Dr. Villar-Valdes failed to accurately read the x-ray of the biopsied tissue that did not correspond with the mammogram of the micro-calcifications. In addition it was alleged Dr. Villar-Valdes failed to recommend a repeat biopsy for patient T.S. Dr. Wolf said it was mitigating that the lead wire was placed 2 centimeters away from the targeted micro-calcifications.

Dr. Villar-Valdez said he failed to recognize the lead wire was placed two centimeters away from the main lesions until after the surgery. Dr. Villar-Valdez also said T.S. missed two follow up appointments, but he was able later to suggest a repeat biopsy.

William R. Martin, III, M.D. led the questioning. Dr. Martin noted it is the physician's responsibility to check that lead wire is in the correct location prior to surgery. Dr. Villar-Valdez said he felt verification of the correct location of the lead wire is a shared responsibility between the radiologist and the physician. Dr. Martin asked about the patient's delay in diagnosis. Dr. Villar-Valdez said from the time of the biopsy until T.S. came to the office, almost one month had passed. Dr. Villar-Valdez said the patient then elected to wait six additional months to have a repeat biopsy. Dr. Martin disagreed with Dr. Villar-Valdez's contention that an earlier a diagnosis for the patient's malignancy may not have made a difference in this case. Dr. Martin stated Dr. Villar-Valdez should have recognized that the patient's specimen mammogram did not demonstrate the abnormality present in the preoperative mammogram, which should have alerted him to attempt an earlier diagnosis.

Paul M. Petelin, Sr., M.D. found that if Dr. Villar-Valdez would have performed a mammogram biopsy as the first procedure, the correct diagnosis would have been made initially. Dr. Villar-Valdez said he agreed the mammogram biopsy was a good route to take, but the patient was an educated patient and insisted on the type of procedure and the day of the procedure as she was going to be leaving for vacation. Dr. Villar-Valdez said the patient's husband was a physician and she and her husband insisted on the needle biopsy procedure rather than allowing Dr. Villar-Valdez to rely on his instincts and recommend a mammogram biopsy.

Dr. Martin said he found Dr. Villar-Valdez's testimony to be forthright with the Board. Dr. Martin noted a mitigating factor that there was not a regular mammographer available on that day the patient insisted on having her procedure. However, Dr. Martin noted Dr. Villar-Valdez admitted to unprofessional conduct by performing an inadequate biopsy for patient T.S. Dr. Martin noted there was no documentation of a conversation between the patient and the physician approximately one month after the inappropriate biopsy or took place, as claimed by Dr. Villar-Valdez for recommendation of a repeat biopsy. Dr. Martin found that there was an eight-month delay in the ultimate diagnosis and treatment of patient T.S. leading to harm.

MOTION: William R. Martin, III, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public and A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Paul M. Petelin, Sr., M.D.

Sharon B. Megdal, Ph.D. spoke against the motion stating she did not find A.R.S. §32-1401 (27)(ll) to be sustained as she did not find actual harm in this case. Dona Pardo, R.N., Ph.D. also spoke against the motion stating the events in this case were a one time occurrence. Patrick N. Connell, M.D. said there were a number of contributing and mitigating circumstances in this case including the fact that T.S. was an educated patient who requested what type of procedure be performed and chose to delay a repeat biopsy.

MOTION: William R. Martin, III, M.D. moved to withdraw the finding of A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 8-yay, 1-nay, 0-abstain 3-recuse, 0-absent
MOTION PASSED.

Dr. Martin noted Dr. Villar-Valdes did not have any prior board history.

MOTION: Sharon B. Megdal, Ph.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for performing an inadequate biopsy and for failure to aggressively pursue a repeat biopsy.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D. and Paul M. Petelin, Sr., M.D., The

following Board Members voted against the motion: Patrick N. Connell, M.D., Patricia R.J. Griffen, Becky Jordan, The following Board Members were recused: Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Lorraine Mackstaller, M.D.
VOTE: 6-yay, 3-nay, 0-abstain 3-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-05-0913A	AMB	PETER C. KUCHARSKI, M.D.	28942	Dismiss

Peter Kucharski, M.D. was present with counsel, Mrs. Robin E. Burgess.

Dr. Huber summarized the case to the Board. A medical malpractice settlement was made on behalf of Dr. Kucharski. The plaintiff alleged he failed to diagnose a patient's lung cancer on x-rays resulting in patient death.

Dr. Kucharski said he is not currently practicing or residing in Arizona. Dr. Kucharski said he urged the patient to obtain further diagnostic testing, but the patient refused.

Tim B. Hunter, M.D. led the questioning. Dr. Hunter noted Dr. Kucharski advised the patient that his blood studies showed he may have lymphoma and should have follow up studies to confirm or deny the disease. Dr. Hunter noted the patient refused follow up studies and lymphoma was subsequently discovered 15-16 months later. Dr. Hunter also noted he reviewed the x-rays in this case and noticed the patient remained stable over a period of three x-rays.

Dona Pardo, R.N., Ph.D. noted there was no action taken in the state of Illinois for this medical malpractice case.

Ms. Burgess said the events in this case relates to care given by Dr. Kucharski approximately 12 years ago. Ms. Burgess said is not residing in Arizona and this case is the only matter on his Arizona license. Ms. Burgess noted the patient in this case refused further testing and work up.

Dr. Hunter said he did not find Dr. Kuchariski misinterpreted the patient's x-ray and said he found no breach from the standard of care in this case.

MOTION: Tim B. Hunter, M.D. moved to Dismiss the case.
SECONDED: Paul M. Petelin, Sr., M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D. and Paul M. Petelin, Sr., M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-05-0439A	AMB	ROBERT M. HURWITZ, M.D.	22057	Advisory Letter for inappropriate use of a medication resulting in a respiratory arrest.

Robert M. Hurwitz, M.D. was present with counsel Mr. Rick Delo.

Carol Peairs, M.D., Medical Consultant summarized case for the Board. A medical malpractice settlement was made on behalf of Dr. Hurwitz. The plaintiff alleged Dr. Hurwitz prescribed an inappropriate amount of Dilaudid to a 16-year-old patient resulting in respiratory arrest. The Outside Medical Consultant sustained the 4 mg dosage of Dilaudid was too high. Dr. Hurwitz contended the patient's problems were due to the speed of administration of the Dilaudid from the nurses rather than the absolute dosage.

Dr. Hurwitz said that at the time he saw the patient he had never had a patient present with symptoms for which he needed to obtain a pain consultation. Dr. Hurwitz said he did not obtain a pain consultation for the patient in this case because he did not read where that had been recommended in the chart. Dr. Hurwitz said he believed the patient's problem was due to rapid administration of the Dilaudid because only one dose of Naltrexone was needed to reverse the medication, showing the Dilaudid dose was probably not too high.

Douglas D. Lee, M.D. led the questioning. Dr. Lee said he did not find the Dilaudid was administered too quickly, but he did find the dosage was too high as the Physician's Desk Reference (PDR) said an adult patient may receive up to 2mg of Dilaudid and this patient received 4mg of Dilaudid. Dr. Hurwitz said the patient was not receiving pain relief and the patient's mother was insistent that the dose continue to be increased. Dr. Hurwitz said he did not use Dilaudid often and so he consulted with a pharmacist who said he could taper up to a 4 mg dose. Dr. Lee noted it should have occurred to Dr. Hurwitz to switch to another drug when the patient continued to receive no relief, rather than continually increasing the dose. Dr. Hurwitz said his practice pattern now is to use Dilaudid in a very small dose.

Mr. Delo said Dr. Hurwitz was not negligent in caring for the patient as he consulted with the pharmacist prior to administering 4mg of Diluaudid and was told this was an appropriate dosage. The patient has subsequently had no long term side effects.

Dr. Lee said he found the standard of care was breached because Dr. Hurwitz gave excessive doses of Dilaudid to a pediatric patient.

MOTION: Douglas D. Lee, M.D. move moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent

MOTION PASSED.

MOTION: Douglas D. Lee, M.D. moved to Draft Finds of Fact Conclusions of Law and Order for a Letter of Reprimand for inappropriate use of a medication resulting in a respiratory arrest.
SECONDED: Ram R. Krishna, M.D.

Tim B. Hunter, M.D. spoke against the motion stating it seemed Dr. Hurwitz took due care to consult with a pharmacist prior to administering the medication, therefore he could not support disciplinary action. Dr. Connell also spoke against the motion noting it was Dr. Hurwitz's testimony that he has now changed his practice and would obtain a pain consultation in the future in a similar situation. Becky Jordan spoke against the motion stating she found it mitigating that the patient's mother continued to insist her daughter receive more medication. Lorraine Mackstaller, M.D. and Robert P. Goldfarb, M.D. spoke against the motion noting this was a one time offense and there were mitigating factors. Dona Pardo, R.N., Ph.D. noted the nurses consulted with the pharmacist and Dr. Hurwitz in this case and because they appropriately consulted with the experts, the case should not be referred to the Arizona State Board of Nursing.

Dr. Lee said he chose not to modify his motion because he felt Dr. Hurwitz used poor judgment in this case by prescribing a drug he was not very familiar with for a problem he did not frequently see in patients.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Ram R. Krishna, M.D., Douglas D. Lee, M.D., Sharon B. Megdal, Ph.D., and Paul M. Petelin, Sr., M.D. The following Board Members voted against the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, R.N., Ph.D.
VOTE: 4-yay, 8-nay, 0-abstain/recuse, 0-absent
MOTION FAILED.

MOTION: Tim B. Hunter, M.D. moved to issue an Advisory Letter for inappropriate use of a medication resulting in a respiratory arrest.
SECONDED: Paul M. Petelin, Sr., M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, R.N., Ph.D. and Paul M. Petelin, Sr., M.D. The following Board Members voted against the motion: Ram R. Krishna, M.D., Douglas D. Lee, M.D., Sharon B. Megdal, Ph.D.
VOTE: 9-yay, 3-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-04-0429A	AMB	JAMES L. ROBROCK, M.D.	16209	Accept the Proposed Consent Agreement for psychiatric monitoring.

James L. Robrock, M.D. was present with counsel Ms. Heather M. Hendrixs.

Mark Nanney, M.D., Chief Medical Consultant summarized the case for the Board. Dr. Robrock's privileges were suspended from Chandler Regional Hospital due to a series of incidents. It was alleged Dr. Robrock left the operating room for approximately one hour while an elderly patient was under general anesthesia and on another occasion entered the operating room unmasked, ungowned and ungloved, and made an incision on the patient announcing the start time and then left the operating room. Allegedly Dr. Robrock directed staff to make a false entry in the medical record, failed to remain current with medical record keeping, used profanity when interacting with hospital staff and admitted use of a growth hormone. An Interim Order for Psychiatric Evaluation was executed on December 12, 2005 and the psychiatric evaluation by Michael Brennan, M.D. concluded Dr. Robrock had no insight into his conduct and its consequences.

Dr. Robrock said there were inaccuracies in the allegations as the events took place within a six month period in 2004 when he was suffering from depression. Dr. Robrock said he takes full responsibility for his actions two years ago and said those actions have not been repeated in the interim during his solo practice.

Patrick N. Connell, M.D. led the questioning. Dr. Connell noted it was acceptable to take no more than a 15-20 minute break during an eight hour procedure. Dr. Robrock said he was verbally threatened by another physician during his break and because he was so upset he filed a complaint. Dr. Robrock said he did not realize how much time had expired when he returned, but he said the patient was under no stress from his extended absence and he actually finished the procedure early. Dr. Robrock said he did enter the operating room unmasked, ungowned and ungloved, but he did not begin the operation, rather he made a scratch mark on the patient to identify the starting point. Dr. Robrock did admit to using profanity on one occasion, but said it was not directed toward anyone. Dr. Connell noted Dr. Robrock's treating physician does not have evidence of a physical exam of Dr. Robrock or a reason for giving him growth hormone. Dr. Robrock said he has been receiving the growth hormone every day for the past three and half to four years and is treated due to a hormone deficiency.

Ms. Hendrixs said Dr. Robrock's therapists have never questioned he was fit to practice. All of the occurrences in this case happened within a short period of time while he was going through a hard time in his life and the actions have not been repeated.

Kathleen Muller, Physician Health Program Manager said PHP recommended Dr. Robrock enter a program as defined in the Professional Renewal Evaluation and Dr. Brennan's report for disruptive physicians. Additionally, PHP recommends Dr. Robrock be required to obtain a treating psychiatrist.

Dr. Connell said the one hour break during an operation and the allegation of violation of sterile technique was a one-time occurrence. However, Dr. Connell noted multiple sources suggested Dr. Robrock undergo treatment. Dr. Connell said he found no evidence Dr. Robrock presents a danger to patients, but because there have been allegations of disruptive behavior, this may have the potential for impacting patient care as physicians are required to be collaborative with other professionals and patients.

MOTION: Patrick N. Connell, M.D. moved for a finding of Unprofessional Conduct in violation of (q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Sharon B. Megdal, Ph.D.

The Board went into Executive Session 6:31 p.m.
The Board returned to Open Session at 6:47 p.m.

Dr. Connell withdrew his motion for a finding of Unprofessional Conduct.

MOTION: Patrick N. Connell, M.D. moved to continue the matter until the close of the Board session the following day and offer the physician a Consent Agreement for appropriate treatment.
SECONDED: Paul M. Petelin, Sr., M.D.

Dr. Connell said he would like the Consent Agreement to accomplish sending the physician to the appropriate therapeutic program to help him solve his disruptive issues. William R. Martin, III, M.D. said Dr. Robrock admitted to unprofessional conduct and there should be a record made for the public to see. Dr. Connell said he believes it is possible plastic surgeons make marks on patients prior to procedures and he said the allegation of violation of sterile technique did not fall below the standard of care. Dr. Connell did find that leaving the patient under anesthesia while the physician took an hour break was a bigger issue. However, there was no patient harm identified, Dr. Robrock finished the procedure within the allotted timeframe and this was an isolated occurrence. Dr. Connell said he felt the physician and the public would be better served by a Consent Agreement that helps rehabilitate the physician.

VOTE: 10-yay, 2-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

On the following day, Thursday, June 8, 2006 the Board reviewed the Proposed Consent Agreement.

William R. Martin, III, M.D. said the Board's position on participation in the confidential Physician's Health Program (PHP) would only be possible if the physician self-reports. Dr. Martin said he believed the physician's Consent Agreement should be a public Order. Sharon B. Megdal, Ph.D. also spoke against the drafted consent agreement stating because it was non-disciplinary and the complaint was originated out of a suspension of hospital privileges.

Christine Cassetta, Board Legal Counsel said the Consent Agreement would appear on the website, but there would be no summary of findings.

Robert P. Goldfarb, M.D. spoke in favor of the Consent Agreement stating the Board was not able to identify any patient harm in this case. Ram R. Krishna, M.D. said the Board found potential for patient harm. Tim B. Hunter, M.D. spoke against the drafted Consent Agreement stating he believed the physician was on the threshold of potentially committing patient harm and felt patients should know Dr. Robrock's history.

Dr. Goldbarb said he thought the Consent Agreement provided sufficient notice to the public.
MOTION: Tim B. Hunter, M.D. moved to accept the Proposed Consent Agreement for psychiatric monitoring.
SECONDED: Patrick N. Connell, M.D.
VOTE: 7-yay, 4-nay, 0-abstain, 0-recuse, 1-absent
MOTION PASSED.

FORMAL HEARING MATTERS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-05-0069A	AMB	WALTER H. JACOBS, M.D.	3829	Accept the Administrative Law Judge Order for Revocation.

Dean Brekke, Assistant Attorney General summarized the case to the Board. Mr. Brekke said Walter Jacobs, M.D. violated the terms of his Consent Agreement with the Board. Mr. Brekke said Dr. Jacobs failed to appear at the Administrative Hearing, and the Administrative Law Judge considered the case and recommended the license be revoked.
MOTION: Patrick N. Connell, M.D. moved to accept the Findings of Fact and Conclusions of Law.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

MOTION: Patrick N. Connell, M.D. moved to accept the Administrative Law Judge Order for Revocation.
SECONDED: Lorraine Mackstaller, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D. and Paul M. Petelin, Sr., M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent

MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-05-0177A MD-05-1029A	AMB J.R.	BRUCE HUNTER, M.D.	24075	Accept the Administrative Law Judge Order for Revocation as amended.

Chris Munns, Assistant Attorney General summarized the case to the Board. Mr. Brekke said Bruce Hunter, M.D. was suspended for internet prescribing. Mr. Brekke also noted Dr. Hunter was uncooperative during the investigation. Mr. Brekke said the Administrative Law Judge recommended Revocation of license.

Christine Cassetta, Board Legal Counsel recommended the Board accept the Administrative Law Judge's Order but with the deletion of Finding of Fact 28 and Conclusion of Law 3 as both items refer to allegations withdrawn by the State and are unnecessary.

MOTION: Patricia R.J. Griffen moved to accept the Findings of Fact and Conclusions of Law.
SECONDED: Patrick N. Connell, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

MOTION: Patricia R.J. Griffen moved to accept the Administrative Law Judge Order for Revocation as amended.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D. and Paul M. Petelin, Sr., M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-06-0164A	AMB	LANCE A. MAY, M.D.	34267	Accept the Administrative Law Judge Order for Revocation as amended.

Dean Brekke, Assistant Attorney General presented the case to the Board. Mr. Brekke said Lance May, M.D. was convicted of child sexual abuse, and charged for solicitation of a prostitute with a United States Government credit card. This information was not disclosed on his application for an Arizona Medical Board license.

Christine Cassetta, Board Legal Counsel said page 3, item 9 of the Administrative Law Judge order quoted only a portion of the Arizona Medical Board license application question, and requested the Board amend the Order to include the compete question. Ms. Cassetta also requested that the statement on page 7, item 8 that the State withdrew the allegation of unprofessional conduct be withdrawn.

MOTION: Tim B. Hunter, M.D. moved to accept Findings of Fact and Conclusions of Law with the addition of the complete application question on page 3, item 9 and the deletion of item 8 on page 7.
SECONDED: William R. Martin, III, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

Tim B. Hunter, M.D. moved to accept the Administrative Law Judge Order for Revocation
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D. and Paul M. Petelin, Sr., M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

THURSDAY, June 8, 2006

CALL TO ORDER
Robert P. Goldfarb, M.D. called the meeting to order at 8:00 a.m.

ROLL CALL
The following Board Members were present: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D. and Paul M. Petelin, Sr., M.D.

CALL TO THE PUBLIC
Dean Brekke introduced Ms. Anne Froedge to the Board as the new Assistant Attorney General who has joined the Licensing and Enforcement Section and will be litigating the Board's cases.

Additional statements issued during the call to the public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-04-0912A	AMB	MAHDI S. AL-BASSAM, M.D.	21073	Draft Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for failure to timely diagnose a known complication of an abdominal aortic stent placement resulting in death.

Deborah Al-Bassam, Mahdi Al-Bassam's wife, was present and spoke during the call to the public. Mrs. Al-Bassam said she is a cardiovascular nurse and has worked with her husband since 1981. She said Dr. Al-Bassam has excellent diagnostic skills very conscientious.

Mahdi S. Al-Bassam, M.D. was present with counsel Mr. Paul J. Giancola.

William R. Martin, III, M.D. said he knows Mr. Giancola, but it will not affect his ability to adjudicate the case. The Board asked that the malpractice cases be presented one at a time.

William Wolf, M.D., Medical Consultant summarized the case to the Board. Dr. Wolf said there were two malpractice settlements made on behalf of Dr. Al-Bassam. The first malpractice case alleged Dr. Al-Bassam failed to diagnose myocardial infarction in a timely fashion. The Outside Medical Consultant found Dr. Al-Bassam deviated from the standard of care by performing an inadequate evaluation of chest pain and for failing to attempt to open the occluded anterior descending artery and the occluded bypass graft for patient F.Z.

Dr. Al-Bassam said he performed an intervention to relieve two lesions for patient F.Z. and there was a resulting dissection from intervention. Dr. Al-Bassam said F.Z. subsequently had shoulder pain, but would not come to hospital to see him initially. Dr. Al-Bassam admitted the patient's refusal was not documented in the medical record. Dr. Al-Bassam said patient F.Z. presented to the emergency room on a later date with complete heart block with hypotension. Dr. Al-Bassam said appropriate intervention was provided and the patient subsequently did well.

Lorraine Mackstaller, M.D. led the questioning. Dr. Mackstaller said dissection of the arteries is a known complication and she did not have an issue with that area of Dr. Al-Bassam's care, however, she did find Dr. Al-Bassam did not adequately address F.Z.'s symptoms when he began complaining of shoulder pain. Dr. Al-Bassam said F.Z.'s shoulder pain was associated with movement and his vital signs were stable. Dr. Al-Bassam said additionally, the EKG did not show signs of myocardial infarction. Dr. Mackstaller noted the medical record did not show Dr. Al-Bassam performed an exam of range of motion in the shoulder and also found Dr. Al-Bassam missed ischemia on F.Z.'s EKG. Dr. Mackstaller had Dr. Al-Bassam explain how to recognize a finding of ischemia and as a result Dr. Mackstaller determined Dr. Al-Bassam did not have a deficiency in his technical skills, but rather missed ischemia in this case.

Mr. Giancola said at the time, both Dr. Al-Bassam and his partner missed ischemia, but they both recommended F.Z. go to emergency room for further work up which may have further revealed the correct diagnosis if the patient would have presented. He said patient F.Z. ultimately did well.

William Wolf, M.D., Medical Consultant summarized the second medical malpractice case stating it was alleged Dr. Al-Bassam negligently performed a percutaneous abdominal aorta angioplasty with intra-arterial stent insertion for patient J.M. resulting in injury to her iliac artery, massive bleeding and death. It was also alleged Dr. Al-Bassam failed to recognize and treat the iliac artery injury and hemorrhage. The Outside Medical Consultant found Dr. Al-Bassam deviated from standard of care by attempting to reposition the iliac stent once it was deployed, failed to properly monitor for blood loss post operatively and failed to appreciate the signs that the patient was in trouble.

Dr. Al-Bassam said he observed J.M.'s stent migrate to a different location and at this time realized the stent was not a fully deployed and was rather acting as a foreign body. Dr. Al-Bassam said the standard of care is to reposition the foreign body. Dr. Al-Bassam said he used a soft wire tip to attempt to reposition the stent, but when he was unable to do so he introduced a second stent. Dr. Al-Bassam said he therefore did not move the stent.

Douglas D. Lee, M.D. noted J.M.'s vital signs showed she was tachycardic and had high blood pressure. Dr. Al-Bassam said he was told the J.M.'s blood pressure and pulse rate was stable, but there could have been some external stressors and she was having family issues while in the hospital and they soon had to restrict visitors to allow the patient's mother to visit only. Dr. Al-Bassam said he spoke to the patient that one of the main complications of the procedure was bleeding and he wanted to treat her with a blood transfusion. Patient J.M. denied the transfusion due to religious preference. Dr. Mackstaller noted hematocrit and hemoglobin tests should have been performed for J.M. Dr. Al-Bassam said he did order that testing, but J.M. was having problems and it prevented the study from being done at that time. Dr. Al-Bassam said this case has since changed his medical practice and he now performs an ultrasound for each patient at the end of every procedure.

Dr. Lee noted that if the hematocrit and hemoglobin test would have returned abnormal, Dr. Al-Bassam admitted he would have done something different in this case.

Mr. Giancola said the attempt to move the stent was prior to its deployment. Mr. Giancola said Dr. Al-Bassam received a report the patient was essentially stable, and the nurses did not inform him they were concerned about J.M's status.

Dr. Mackstaller bifurcated the cases for the voting of unprofessional conduct. Dr. Mackstaller said that in the first medical malpractice case Dr. Al-Bassam's care was appropriate for F.Z. until a week after F.Z.'s bypass surgery when he did not recognize ischemia on EKG. Dr. Mackstaller found it mitigating that F.Z. refused to go to the emergency room on multiple occasions, though this was not documented in the medical record.

MOTION: Lorraine Mackstaller, M.D. moved for a finding of moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Patrick N. Connell, M.D.

Tim B. Hunter, M.D. said he disagreed with the motion stating the misinterpretation of the EKG was a moot point because F.Z. refused to go to the hospital in a timely manner. Dr. Mackstaller said she believed if Dr. Al-Bassam would have recognized the myocardial infarction he would have been more assertive in telling F.Z. to present to the hospital.

VOTE: 11-yay, 1-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

Dr. Mackstaller said Dr. Al-Bassam fell below the standard of care on the second case because she felt that, although Dr. Al-Bassam said he did not move the stent, Dr. Mackstaller found the manipulation of it could have caused a microscopic laceration of the J.M.'s artery. Dr. Mackstaller said Dr. Al-Bassam also fell below the standard of care because he did not recognize and timely treat complications that resulted in J.M.'s death. Dr. Mackstaller said J.M.'s death probably could have been prevented if the complication was noticed early on.

MOTION: Lorraine Mackstaller, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public, and A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Patrick N. Connell, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

Dr. Mackstaller combined the two Medical Malpractice cases for the disciplinary motion.

MOTION: Lorraine Mackstaller, M.D. moved to issue an Advisory Letter for failure to timely diagnose a known complication of an abdominal aortic stent placement resulting in death.
SECONDED: Becky Jordan

Paul M. Petelin, Sr., M.D. spoke against the motion stating the second case rose to a disciplinary level because Dr. Al-Bassam failed to order a hemoglobin and hematocrit test for J.M. causing the window of opportunity to be lost for that patient. Patrick N. Connell, M.D. also spoke against the motion and stating he felt the second case rose to the level of a Letter of Reprimand. William R. Martin, III, M.D. spoke in favor of a disciplinary action, but noted there were mitigating factors such as J.M.'s family issues and turmoil that could have effected J.M.'s vital signs, and the fact that J.M. refused blood products may have caused Dr. Al-Bassam to be less aggressive in her treatment.

MOTION: Lorraine Mackstaller, M.D. amended the motion to Draft Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for failure to timely diagnose a known complication of abdominal aortic stent placement resulting in death.
SECONDED: Becky Jordan
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D. and Paul M. Petelin, Sr., M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-04-0827A MD-05-0021A MD-05-0484A MD-05-1089A	S.R. AMB K.B. A.D.	MICHAEL CHASIN, M.D.	8082	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for unprofessional conduct, including inappropriate sexual conversations with patients. Three Years Probation for Board Staff approved psychological therapy.

Michael Chasin, M.D. was present with Counsel Mr. Paul J. Giancola.

Patient A.D. was present and spoke during the call to the public. Patient A.D. said Dr. Chasin kissed his buttocks after performing a rectal exam. A.D. said he wanted to come forward with the complaint to protect other patients. A.D. alleged that at almost every visit Dr. Chasin made inappropriate sexual comments to him.

Tina Geiser, Senior Medical Investigator summarized the four cases brought to the Board. Ms. Geiser said three of the complaints were for inappropriate sexual comments and the fourth complaint alleged inappropriate touching. Ms. Geiser said Dr. Chasin admitted to the allegations.

Dr. Chasin said the allegations were basically true and said he had since participated in a boundary course. Dr. Chasin said he used humor to help patients feel comfortable talking about sensitive issues such as sexual dysfunction and prostate cancer, but realizes now he offended people. Dr. Chasin said these events occurred during a very distressing time in his life and have not occurred since.

Paul M. Petelin, Sr., M.D. led the questioning. Dr. Petelin asked Dr. Chasin to describe the events in each of the cases. Dr. Chasin admitted an inappropriate sexual conversation with the patient in case MD-04-0827A and said he did not know how it occurred. Dr. Chasin said the patient had said she was comfortable with the conversation, but he said he now better understands boundary issues and the power of a physician and is more considerate of patients. Dr. Chasin said for case MD-05-0021A, he said he made a joke about doing a rough prostate exam because he was trying to punish the patient, but in truth, he did not perform the prostate exam any differently than for any other patient. Dr. Chasin said in the case MD-05-0484A he discussed sexual dysfunction following cancer with the patient and his wife and mentioned some of his own experiences. Dr. Chasin said he no longer discusses this in detail unless the patient asks. Dr. Chasin said his staff failed to tell him the patient called four times following the appointment. Dr. Petelin noted the calls were well documented by his staff in a record. Dr. Chasin said for case

MD-05-1089A he admitted to kissing A.D. on the buttocks after a prostate exam, but said he knows it was inappropriate and would not do that again.

Dona Pardo, R.N., Ph.D. asked Dr. Chasin what he has done to change since these occurrences in the four cases. Dr. Chasin said he finished a boundary violation course has reduced his patient case load and no longer focuses all of this time on medicine.

Kathleen Muller, Physician Health Program Manager, said Dr. Chasin completed a Psychosexual Evaluation and the evaluator recommended Dr. Chasin undergo psychological therapy to address behavioral patterns.

Dr. Petelin said he found the inappropriate comments made by Dr. Chasin posed psychosocial trauma to the patients, however, he found the incident of inappropriate contact with A.D. was done more in jest than as a sexual advance.

MOTION: Paul M. Petelin, Sr., M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Ram R. Krishna, M.D.

Sharon B. Megdal, Ph.D. spoke against the motion stating because of the kiss given to A.D., the motion should include A.R.S. §32-1401 (27)(z) - Engaging in sexual conduct with a current patient or with a former patient within six months after the last medical consultation unless the patient was the licensee's spouse at the time of the contact or, immediately preceding the physician-patient.

Dr. Petelin said he believed allegations of sexual misconduct on the record would mislead the public. Lorraine Mackstaller, M.D. said she believed the kiss on the buttocks was a sexual advance.

VOTE: 7-yay, 5-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

MOTION: Paul M. Petelin, Sr., moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for unprofessional conduct, including inappropriate sexual conversations with patients. Three Years Probation for Board Staff approved psychological therapy.
SECONDED: Douglas D. Lee, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., Dona Pardo, R.N., Ph.D. and Paul M. Petelin, Sr., M.D., The following Board Members voted against the Motion: Ram R. Krishna, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D.
VOTE: 9-yay, 3-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-04-0373B	AMB	ROGER A. DAVIS, M.D.	5798	Advisory Letter for continuing to prescribe a prescription drug without monitoring the patient for potential side effects.

Roger A. Davis, M.D. was present with counsel Mr. Tom Slutes.

Tim B. Hunter, M.D. recused himself from the case. Robert P. Goldfarb, M.D. said he knows Mr. Slutes but it would not affect his ability to adjudicate the case.

Carol Peairs, M.D., Medical Consultant summarized the case for the Board. Dr. Peairs said the Outside Medical Consultant (OMC) found Dr. Davis prescribed Reglan to a patient without documenting the risks or side effects. Dr. Davis renewed the patient's prescription by fax and did not see the patient to monitor for side effects. The OMC sustained actual harm because the patient subsequently developed tardive dyskinesia, which is usually irreversible.

Robert P. Goldfarb, M.D. led the questioning. Dr. Davis said he did explain the side effects of the Reglan to the patient, but because he was not the patient's primary physician, he told the patient to see his primary care physician every month and to contact him if he experienced any side effects of the medication. Robert P. Goldfarb, M.D. noted Dr. Davis did not inform the primary care physician he had placed the patient on Reglan and would not be seeing the patient unless problems arose. Douglas D. Lee, M.D. said the physician who writes the prescription is responsible for monitoring for side effects of the prescription. Ram R. Krishna, M.D. noted Dr. Davis was refilling the patient's Reglan, but felt he was not responsible for the course of treatment.

Dr. Davis said be believed Reglan could be used in long term therapy without worrying about tardive dyskinesia. Dr. Davis said he expected either the patient or the primary care physician to let know the patient was experiencing side effects. Dr. Davis said if he would have observed the medication's side effects on the patient he would have discontinued the Reglan.

Robert P. Goldfarb, M.D. said he was concerned that Dr. Davis did not record the risks or complications of Reglan in the chart and there was not a proper hand-off of the case to the patient's primary care physician stating he was no longer going to be following the medication.

MOTION: Robert P. Goldfarb, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401(27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Paul M. Petelin, Sr., M.D.

VOTE: 11-yay, 0-nay, 0-abstain, 1-recuse, 0-absent
MOTION PASSED.

Lorraine Mackstaller, M.D. said it was the responsibility of the specialist to give a clean hand off to the primary care physician in order for the primary care physician to be able to follow up on the medication prescribed.

MOTION: Robert P. Goldfarb, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for continuing to prescribe a prescription drug without monitoring the patient for potential side effects.
SECONDED: Ram R. Krishna, M.D.

Dr. Mackstaller spoke against the motion stating tardive dyskinesia is an incredibly rare side effect of Reglan and a disciplinary action is not warranted. Douglas D. Lee, M.D. also spoke against the motion stating an Advisory Letter can help the physician see he is responsible for the medications he prescribes.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Robert P. Goldfarb, M.D., Ram R. Krishna, M.D. and, Paul M. Petelin, Sr., M.D., The following Board Members voted against the motion: Patrick N. Connell, M.D., Patricia R.J. Griffen, Becky Jordan, Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, R.N., Ph.D., The following Board Member was recused: Tim B. Hunter, M.D.
VOTE: 3-yay, 8-nay, 0-abstain, 1-recuse, 0-absent
MOTION FAILED.

MOTION: Lorraine Mackstaller, M.D. moved to issue an Advisory Letter for continuing to prescribe a prescription drug without monitoring the patient for potential side effects.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D. and Paul M. Petelin, Sr., M.D. The following Board Member was recused: Tim B. Hunter, M.D.
VOTE: 11-yay, 0-nay, 0-abstain 1-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-05-0576A	AMB	ROBERT J. ALLEN, M.D.	15874	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to refer a patient for a cardiac consultation. One year Probation with 20 hours Board Staff approved CME in electrocardiograph interpretation. The CME is in addition to the CME required for license renewal. Probation terminates when physician provides satisfactory proof of attendance.

Robert J. Allen, M.D. was present without counsel.

Roderic Huber, M.D., Medical Consultant summarized the case for the Board. Dr. Huber said a patient presented with multiple risk factors for coronary artery disease and a family history of coronary artery disease. Dr. Allen, however, did not perform a thorough cardiac evaluation and did not consult with any cardiologists concerning the patient.

Dr. Allen denied that he failed to diagnose coronary artery disease and failed to aggressively obtain a cardiology consult. Dr. Allen said he recognized the patient had chest pain and shortness of breath with exertion, but she had been in the hospital for three days and did not have chest pain when she saw him shortly after discharge from the hospital. Dr. Allen said he did recommend the patient see a cardiologist, but she refused.

Lorraine Mackstaller, M.D. led the questioning. Dr. Mackstaller noted it was Dr. Allen's testimony that he did not have any formal training in reading electrocardiograms (EKGs) although he does perform EKGs in his office and one of his partners either interprets it or faxes to a cardiologist if there is an abnormality. Dr. Mackstaller noted the patient was non-compliant with Dr. Allen's referral to a cardiologist. Dr. Mackstaller also noted Dr. Allen's second EKG on the patient showed an abnormality, but Dr. Allen said he could not recall if he saw that x-ray. Dr. Mackstaller said Dr. Allen should have obtained the EKG from the hospital showing the stress test was not normal as it had been stopped due to fatigue, leg pain and chest pain. Dr. Mackstaller noted the patient was inappropriately informed that the stress test was "normal".

Tim B. Hunter, M.D. suggested that all of the films in Dr. Allen's office should be reviewed by a cardiologist. Patrick N. Connell, M.D. said this patient was the poster child for heart attack and the standard of care would be to obtain an immediate and emergent referral for a cardiac evaluation and not suggest the patient be seen in three weeks.

Dr. Mackstaller said Dr. Allen contended the patient did not have chest pain when she presented to his office following her hospital visit. Dr. Mackstaller did not find it mitigating that the patient was not a having heart attack while in Dr. Allen's office because she was having cardiovascular symptoms that Dr. Allen failed to recognize. Dr. Mackstaller found that if Dr. Allen had recognized the EKG as abnormal he may have been more aggressive in referring the patient to a cardiologist quickly. Dr. Mackstaller found Dr. Allen failed to meet the standard of care by not accurately assessing the patient, failing to have the patient's EKG read by a qualified interpreter and failing to timely refer the patient to a subspecialist. Dr. Mackstaller said the patient died.

MOTION: Lorraine Mackstaller, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401(27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public and A.R.S. §32-1401(27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Patrick N. Connell, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

Lorraine Mackstaller, M.D. noted that although the patient was non-compliant the patient did not recognize the severity of her disease because Dr. Allen also failed to recognize her cardiovascular symptoms and, therefore, could not have conveyed this to the patient. Dr. Mackstaller also noted Dr. Allen had an extensive history of prior Board actions.

MOTION: Lorraine Mackstaller, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to refer a patient for a cardiac consultation. One year Probation with 20 hours Board Staff approved CME in electrocardiograph interpretation. The CME is in addition to the CME required for license renewal. Probation terminates when physician provides satisfactory proof of attendance.
SECONDED: Patrick N. Connell, M.D.

Paul M. Petelin, Sr., M.D. noted that Dr. Allen had received two prior Board actions regarding failure to refer patients in a timely manner for a consultation.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D. and Paul M. Petelin, Sr., M.D.
MOTION: Ram R. Krishna, M.D. moved to refer the Physician Assistant in this case to the Arizona Regulatory Board of Physician Assistants.
SECONDED: William R. Martin, III, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-03-0015A MD-03-0474A	AMB	INNA OGANDZHANOVA, M.D.	28680	Continue the matter until the August 9-10th, 2006 Arizona Medical Board Meeting.

Inna Ogandzhanova, M.D. was present without counsel. Dr. Ogandzhanova said she did not have adequate time to arrange legal counsel due to the death of her son.

The Board went into Executive Session 1:45 p.m.
The Board returned to Open Session at 1:51 p.m.

Robert P. Goldfarb, M.D. told Dr. Ogandzhanova she could be granted a continuance until the next Board Meeting Dr. Ogandzhanova accepted the Board's offer to come to the August 9th – 10th Board Meeting. Dr. Ogandzhanova said she understood she would have to be prepared at the next Board Meeting and would not be granted any additional continuances.

MOTION: Tim B. Hunter, M.D. moved to continue the matter until the August 9-10th, 2006 Arizona Medical Board Meeting.
SECONDED: Patrick N. Connell, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-04-1545A	AMB	FRANK IORIO, M.D.	12233	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to do a needle biopsy and for failure to recognize a laryngeal nerve injury post surgery.

Frank Iorio, M.D. was present with counsel Mr. Michael Golder.

Tim B. Hunter, M.D. said he knows Dr. Iorio, but it would not affect his ability to adjudicate the case.

William Wolf, M.D., Medical Consultant summarized the case to the Board. A medical malpractice settlement was made on behalf of Dr. Iorio alleging he negligently performed a total thyroidectomy resulting in vocal cord paralysis.

Dr. Iorio said the patient remained adamant about not undergoing a fine needle aspiration biopsy and so he agreed to perform a thyroidectomy.

Douglas D. Lee, M.D. led the questioning. Dr. Lee noted the patient had a raspy voice post-operatively, but Dr. Iorio attributed this to the swelling of the patient's thyroid because the raspy voice would come and go and seemed to coincide with the swelling.

Dr. Lee asked Dr. Iorio to describe why he did a total thyroidectomy. Dr. Iorio explained that during the operation he discovered the patient had a shrunken left thyroid lobe and thought at the time of the surgery there was a chance of thyroid cancer and, because the patient had a severe inflammatory change, he did not want to re-enter the neck unnecessarily.

Dr. Iorio said he believed the reason the patient most likely ended up with vocal cord paralysis was because there may have been scarring and inflammation at the site of surgery and also associated with the disease process the patient had.

Paul M. Petelin, Sr., M.D. said his main concern was that a fine needle biopsy was not done for the patient and the patient should not dictate when the physician operates. Dr. Petelin said the burden of proof was on Dr. Iorio to notice there was nerve injury when the patient presented post operatively. Dr. Petelin said he did not find the removal of the patient's left thyroid lobe to be concerning.

Dr. Wolf, Medical Consultant said it was standard of care to do a needle biopsy in this case, but it was not known whether or not that would have altered the patient's course if it was performed.

Dr. Lee said he found Dr. Iorio fell below the standard of care for failure to do a needle biopsy and for failure to recognize the patient's nerve injury following thyroid surgery.

MOTION: Douglas D. Lee, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401(27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 11-yay, 1-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

Dr. Lee said the events in this case were a one-time occurrence for Dr. Iorio.

MOTION: Douglas D. Lee, M.D. moved to issue an Advisory Letter for failure to do a needle biopsy and for failure to recognize a laryngeal nerve injury post surgery. This was a technical violation.
SECONDED: Patrick N. Connell, M.D.

Dr. Goldfarb spoke against the motion stating he did not feel an Advisory Letter was sufficient when the physician did not exercise due diligence when the patient had a very significant problem following surgery. Dr. Petelin also spoke against the motion stating he was not concerned with the technical error in this case, but was concerned rather that Dr. Iorio did not recognize the complication and follow the patient until it resolved.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., The following Board Members voted against the motion: Robert P. Goldfarb, M.D., Becky Jordan, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, Sr., M.D.
VOTE: 6-yay, 6-nay, 0-abstain, 0-recuse, 0-absent
MOTION FAILED.

MOTION: Paul M. Petelin, Sr., M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to do a needle biopsy and for failure to recognize a laryngeal nerve injury post surgery.
SECONDED: Ram R. Krishna, M.D.

Dr. Hunter spoke against the motion stating he did not feel needle biopsy would have changed the patient's course in this case.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D. and Paul M. Petelin, Sr., M.D. The following Board Members voted against the motion: Patricia R.J. Griffen, Tim B. Hunter, M.D., Douglas D. Lee, M.D.
VOTE: 9-yay, 3-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

The meeting was adjourned at 5:00 p.m.

Timothy C. Miller, J.D., Executive Director